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§15–10D–01.

(a) In this subtitle the following words have the meanings indicated.

(b) "Appeal" means a protest filed by a member, a member's representative, or a health care provider with a carrier under its internal appeal process regarding a coverage decision concerning a member.

(c) "Appeal decision" means a final determination by a carrier that arises from an appeal filed with the carrier under its appeal process regarding a coverage decision concerning a member.

(d) "Carrier" means a person that offers a health benefit plan and is:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization;

(5) a self–funded student health plan operated by an independent institution of higher education, as defined in § 10–101 of the Education Article, that provides health care to its students and their dependents; or

(6) except for a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that offers a health benefit plan subject to regulation by the State.

(e) "Complaint" means a protest filed with the Commissioner involving a coverage decision other than that which is covered by Subtitle 10A of this title.

(f) (1) "Coverage decision" means:

(i) an initial determination by a carrier or a representative of the carrier that results in noncoverage of a health care service;

(ii) a determination by a carrier that an individual is not eligible for coverage under the carrier's health benefit plan; or

(iii) any determination by a carrier that results in the rescission of an individual's coverage under a health benefit plan.

(2) "Coverage decision" includes nonpayment of all or any part of a claim.

(3) "Coverage decision" does not include:

(i) an adverse decision as defined in § 15–10A–01(b) of this title; or

(ii) a pharmacy inquiry.

(g) "Designee of the Commissioner" means any person to whom the Commissioner has delegated the authority to review and decide complaints filed under this subtitle, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

(h) (1) "Health benefit plan" means:

(i) a hospital or medical policy or contract, including a policy or contract issued under a multiple employer trust or association;

(ii) a hospital or medical policy or contract issued by a nonprofit health service plan;

(iii) a health maintenance organization contract; or

(iv) a dental plan organization contract.

(2) "Health benefit plan" does not include one or more, or any combination of the following:

(i) long–term care insurance;

(ii) disability insurance;

(iii) accidental travel and accidental death and dismemberment insurance;

(iv) credit health insurance;

(v) a health benefit plan issued by a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article;

(vi) disease–specific insurance; or

(vii) fixed indemnity insurance.

(i) "Health care provider" means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19–301 of the Health – General Article.

(j) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(k) (1) "Member" means:

(i) a person entitled to health care services under a policy, plan, or contract issued or delivered in the State by a carrier; or

(ii) with regard to an individual who is determined by a carrier not to be eligible for a health benefit plan, an individual who has applied for coverage under a health benefit plan.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

(l) "Member's representative" means an individual who has been authorized by the member to file an appeal or a complaint on behalf of the member.

(m) "Pharmacy benefits manager" has the meaning stated in § 15–1601 of this title.

(n) "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a member to a carrier or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under a health benefit plan.

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